TIME STUDY - DAILY LOG

Employee Name: _____

Date: _____

Agency No. _____ Agency Name: _____

MINUTES SPENT ON WIC ACTIVITIES/DAILY

Time Slot	Client Services	Nutrition Education	Breast-feeding	Administration
6AM - 7AM				
7AM - 8AM				
8AM - 9AM				
9AM - 10AM				
10AM - 11AM				
11AM - 12PM				
12PM - 1PM				
1PM - 2PM				
2PM - 3PM				
3PM - 4PM				
4PM - 5PM				
5PM - 6PM				
6PM - 7PM				
7PM - 8PM				
8PM - 9PM				
DAILY TOTALS	_____ MINUTES	_____ MINUTES	_____ MINUTES	_____ MINUTES
HOURS (Total Minutes/60)				

TIME STUDY MUST BE DONE BY EMPLOYEES PAID OUT OF THE WIC GRANT.

TIME STUDIES MUST BE CONDUCTED ON THE FIRST WEEK OF EVERY MONTH.

TIME STUDIES MUST BE RECEIVED BY THE STATE OFFICE NO LATER THAN THE 30TH OF EACH MONTH.

I certify this information to be true and correct.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

TIME STUDY - SUMMARY

Employee Name: _____

WIC Position/Title: _____

Agency No. _____ Agency Name: _____

HOURS SPENT ON WIC ACTIVITIES - FROM DAILY LOG SHEETS

Date	Client Services	Nutrition Education	Breastfeeding Promotion	Administration	Total Hours for Day
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
TOTALS	0 Hours	0 Hours	0 Hours	0 Hours	0 Total hours

SALARY AND BENEFITS CALCULATION BY COST CATEGORY

Annual Salary and Benefits Charged to WIC Grant	Client Services	Nutrition Education	Breastfeeding Promotion	Administration
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

I certify this information to be true and correct.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

TIME STUDY - SUMMARY

Employee Name: _____

WIC Position/Title: _____

Agency No. _____ Agency Name: _____

HOURS SPENT ON WIC ACTIVITIES - FROM DAILY LOG SHEETS

Date	Client Services	Nutrition Education	Breastfeeding Promotion	Administration	Total Hours for Day
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
TOTALS	0 Hours	0 Hours	0 Hours	0 Hours	0 Total hours

SALARY AND BENEFITS CALCULATION BY COST CATEGORY

Annual Salary and Benefits Charged to WIC Grant	Client Services	Nutrition Education	Breastfeeding Promotion	Administration
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

I certify this information to be true and correct.

Signature: _____

Printed Name: _____

Title: _____

Date: 12/17/2003

TIME STUDY - SUMMARY

Employee Name: _____

WIC Position/Title: _____

Agency No. _____ Agency Name: _____

HOURS SPENT ON WIC ACTIVITIES - FROM DAILY LOG SHEETS

Date	Client Services	Nutrition Education	Breastfeeding Promotion	Administration	Total Hours for Day
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
TOTALS	0 Hours	0 Hours	0 Hours	0 Hours	0 Total hours

SALARY AND BENEFITS CALCULATION BY COST CATEGORY

Annual Salary and Benefits Charged to WIC Grant	Client Services	Nutrition Education	Breastfeeding Promotion	Administration
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

I certify this information to be true and correct.

Signature: _____

Printed Name: _____

Title: _____

Date: 12/17/2003

TIME STUDY - SUMMARY

Employee Name: _____

WIC Position/Title: _____

Agency No. _____ Agency Name: _____

HOURS SPENT ON WIC ACTIVITIES - FROM DAILY LOG SHEETS

Date	Client Services	Nutrition Education	Breastfeeding Promotion	Administration	Total Hours for Day
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
TOTALS	0 Hours	0 Hours	0 Hours	0 Hours	0 Total hours

SALARY AND BENEFITS CALCULATION BY COST CATEGORY

Annual Salary and Benefits Charged to WIC Grant	Client Services	Nutrition Education	Breastfeeding Promotion	Administration
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

I certify this information to be true and correct.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

PROPERTY INVENTORY REPORT

Local Agency No: _____ Page _____ of _____

Local Agency Name: _____ Clinic Site: _____

Item #	State Property Tag #	Serial #	Description of Item	Condition				Acquisition Date	Acquisition Cost
				New	Good	Acceptable	Unusable		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

Please note: Record all non-expendable equipment over $500 purchased with WIC funds.
Record State Property Tag Numbers for all equipment over $500 purchased by the State WIC Office.

I certify this information to be true and correct.
(Sign last page only)

Signature: _____
Printed Name: _____
Title: _____
Date: _____

WIC Program Expenditure Report

FFY _____

Agency No: _____ SFY _____

Agency Name _____ Month of _____ 20 _____

Period: From _____ to _____

Expenditures This Month

	Funds Awarded	Net Expend. Prior Periods	Client Services	Nutrition Education	Breastfeeding Promotion	General Administration	Total Expenditures This Month	Total Obligations	Total Accum. Expenditures & Obligations	% of Total Expended	Balance of Funds
Personal Services											
Travel											
Facility Expense											
Supplies											
Equipment											
Other Direct Expenses											
Total Direct Expenses											
Total Direct Cost											
Indirect Cost %											
Total Cost											

_____ Initial Report

_____ Revised Report #_____

Due Date: 20 days after close of each month.

Mail to:
Department of Health & Social Services
Division of Public Health
Section of Maternal, Child, and Family Health - WIC
P.O. Box 110612
Juneau, Alaska 99811-0612

Prepared By: _____

Typed Name: _____

Title: _____

Phone: _____

Date: _____

Grant: _____

STATE OF ALASKA Department of Health & Social Services

REQUEST FOR LINE ITEM BUDGET REVISION

Grantee		Address:	
Project: Name: WIC Program		Address: Section of Maternal, Child & Family Health P.O. Box 110612, Juneau, Alaska 99811-0612	
Grant Number	Fiscal Year	Date Received	Date Returned

BUDGET REVISION SUMMARY

Budget Categories	Current Approved Budget	Revised Budget Request	Revision Increase/Decrease
100 Personal Service			0
200 Travel			0
300 Facility Expenses			0
400 Supplies			0
500 Equipment			0
600 Other			0
Total Direct Costs			0
Indirect Costs			0
TOTAL	0	0	0

Explanation (See bottom of page for format)

(use the reverse side or additional sheets if necessary)

The Grantee hereby agrees that this revision is to be a part of and subject to all conditions in the original Grant Award.

Project Director Date	Approved
City Manager/ Date Corporate President	
DHSS Fiscal Date	Disapproved
DHSS Grants Administrator Date	Revision Number